Attachment H

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-00001/9)

QUEST Integration Renewal Application

The State of Hawai'i, Department of Human Services (the State) is requesting approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to renew and amend the "QUEST Integration" (Project Number 11-W-00001/9) demonstration under Section 1115(a) of the Social Security Act for an additional five years. The State's existing Section 1115 Demonstration is approved through July 31, 2024, and this application will request approval of a five-year renewal beginning August 1, 2024 and continuing through July 31, 2029.

Pursuant to 42 C.F.R. § 431.408, Med-QUEST Division (MQD), Hawaii's Medicaid Agency, gives notice of the State's intent to file this Section 1115 Demonstration renewal and amendment. This public notice, issued October 16, 2023, provides information on this demonstration, including an overview of the program and its objectives; details regarding eligibility and the care delivery system; proposed hypotheses and evaluation approaches; proposed waiver and expenditure authorities; impact to eligibility and budget neutrality; and opportunities for public comment and dates of public hearings.

The State invites the public to comment on the draft Section 1115 Demonstration renewal application, available online at https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00. Written comments may be submitted by email to PPDO@dhs.hawaii.gov using "Section 1115 Demonstration Feedback" in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

Hawai'i 'Ohana Nui Project Expansion (HOPE) Strategic Framework

The State is committed to supporting and creating healthy families and healthy communities by empowering Hawai'i residents to improve and sustain their wellbeing. Developed as a roadmap to achieve this vision, the HOPE program provides a "north star" to guide the development of Hawaii's delivery system reform initiatives, including this Section 1115 Demonstration renewal application.

The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

- Assuring continued access to health insurance and health care;
- Emphasis on whole person and whole family care over their life course;

- Address the social drivers of health and health-related social needs;
- Emphasis on health promotion, prevention and primary care;
- Emphasis on investing in system-wide changes; and
- Leverage and support community initiatives.

HOPE activities—including those reflected in the renewal application—focus on four strategic areas:

- Invest in primary care, prevention, and health promotion;
- Improve outcomes for high-need, high-cost individuals;
- Implement payment reform and alignment; and
- Support community driven initiatives to improve population health.

Demonstration Background, Objectives, and Renewal Request

Demonstration Background

Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii's Section 1115 Demonstration project to provide comprehensive benefits to its Medicaid enrollees through a competitive managed care delivery system. Since its implementation, CMS has renewed the QUEST demonstration six times. Over the years, the State has made significant changes to the demonstration.

The program was designed to increase access to health care and control the rate of annual increases in health care expenditures. It has also served as a mechanism for delivery system innovation, enabling Hawai'i to advance its policy goals and improve the health and well-being of Hawai'i residents. QUEST stands for:

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST members.

Demonstration Objectives

Building on the HOPE vision and accomplishments of the existing Section 1115 Demonstration, this renewal introduces new strategies to execute on the same overarching objectives as the current demonstration. As such, the State's objectives are to:

- Improve health outcomes for Medicaid enrolled individuals covered under the demonstration;
- Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Address health determinants to improve health outcomes and lower healthcare costs.

Demonstration Renewal Request

Hawai‘i is requesting a five-year renewal of most of the waiver and expenditure authorities contained in the QUEST Integration 2019 Section 1115 Demonstration and is proposing new authorities to enable the State to continue its whole-person approach to care. The proposed authorities reflect the State's commitment to identifying and addressing social drivers of health. In concert with this Section 1115 Demonstration amendment and renewal, the State will separately seek new or exercise existing authorities via the State Plan, Section 1915(c) Waiver, and managed care contracts to expand or modify certain benefits or eligibility criteria for select Medicaid beneficiaries. Together, these authorities will enable MQD to continue championing its mission of empowering Hawai‘i residents to improve and sustain wellbeing.

Current authorities that will be renewed and may be amended include:

- **QUEST Integration Mandatory Managed Care:** Renew authority to continue providing services through a mandatory managed care delivery system. Hawai‘i seeks a technical correction related to reporting and a minor waiver authority to expand out-of-state former foster youth eligibility.
- **Behavioral Health:** Renew authority to continue providing behavioral health benefits as approved and described in the behavioral health protocol.
- **Home- and Community-Based Services (HCBS):** Renew authority to continue providing HCBS, with several proposed amendments. Major amendments include: (1) the addition of assisted living facility services as a new benefit for individuals who are assessed to be at risk of deteriorating to institutional level of care, and (2) continuing select Attachment K flexibilities, including telehealth and e-signature authorities, enacted as a result of the COVID-19 pandemic.
- **Community Integration Services (CIS)**: Renew authority to continue providing housing-related services to eligible beneficiaries; this program will be renamed "Community Integration Services Plus (CIS+)." Services under the current program include outreach, pre-tenancy supports, tenancy sustaining supports, and limited rental assistance. Under the renewal, MQD seeks to include expanded rental assistance and new medical respite benefits.

New requests include federal matching funds related to:

- **Continuous Eligibility for Children:** Provide continuous eligibility for children ages 0 to 6 and continuous two-year eligibility for children ages 6 to 19.
- **Pre-Release Services for Justice-Involved Individuals:** Provide targeted services to eligible justice-involved populations 90-days pre-release from incarceration. Pre-release services include, as clinically appropriate, case management and care coordination, physical and behavioral health clinical consultation services, lab and radiology services,

and, for use post-release into the community, durable medical equipment (DME) and a minimum 30-day supply of medications.

- **Nutritional Supports:** Provide nutritional supports for eligible beneficiaries including nutrition education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and medically tailored meals or groceries.
- **Native Hawaiian Traditional Healing Practices:** Provide Native Hawaiian Traditional Healing Practices for eligible beneficiaries, not limited to those identifying as Native Hawaiian. Native Hawaiian Traditional Healing Practices include:
    - ***Lomilomi**:* Native Hawaiian Traditional Healing Practice of physiotherapy and massage;
    - ***Hula**:* Native Hawaiian form of dance, offering physical movement classes that seek to improve health through physical activity, mindfulness practices, and social interaction;
    - ***Hoʻoponopono**:* Native Hawaiian Traditional Healing Practice of peacemaking, intended to restore and maintain healthy relationships;
    - ***ʻAi pono**:* Native Hawaiian Traditional Healing Practice of holistic nutrition therapy;
    - ***Lāʻau lapaʻau**:* Native Hawaiian Traditional herbalist healing practice; and,
    - ***Hāpai hānau***: Native Hawaiian Traditional midwifery practices.
- **Contingency Management:** Pilot Contingency Management (CM) for beneficiaries with a qualifying substance use disorder (SUD), including stimulant use disorders (StimUDs) and opioid use disorders (OUDs). CM will consist of a complementary course of SUD treatment and a series of motivational incentives to advance SUD treatment goals.
- **Infrastructure Funding:** Claim federal matching funds on infrastructure spending to support capacity building for and implementation of health-related social need (HRSN) services requested in this renewal.
- **Designated State Health Programs (DSHP):** Claim federal matching funds for State expenditures on DSHP and leverage those matching funds to support the development and implementation of 1115 Demonstration initiatives that address HRSN.

Eligibility and Care Delivery System

Eligibility

The State provides coverage to children and adults who are eligible under the Medicaid state plan as well as additional children and adults (including former adoption assistance children, certain parents, and certain individuals who receive home and community based (HCBS) services). The groups currently eligible for Medicaid are described in Table 1; this table does not reflect the proposed eligibility changes requested in the demonstration application, such as continuous eligibility policies for children.

Table 1. Summary of Section 1115 Demonstration Requests.

Mandatory State Plan Groups

Mandatory State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Parents or Caretaker Relatives	Sections 1902(a)(10)(A)(i)(I), (IV), (V) and 1931(b), (d) of the Social Security Act 42 CFR 435.110	Up to and including 100% FPL
Pregnant Women	Section 1902(a)(10)(A)(i)(III)-(IV) of the Social Security Act 42 CFR 435.116	Up to and including 191% FPL
	Section 1902(e)(5)-(6) of the Social Security Act 42 CFR 435.170	Extended and continuous eligibility for pregnant women
Infants	Sections 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(B) of the Social Security Act 42 CFR 435.118(c)(2)(iii)	Infants up to age 1, up to and including 191% FPL
	Section 1902(e)(4) of the Social Security Act 42 CFR 435.117	Deemed newborn children
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Children	Sections 1902(a)(10)(A)(i)(VI)-(VII) and 1902(l)(1)(C)-(D) of the Social Security Act 42 CFR 435.118	Children ages 1 through 18, up to and including 133% FPL
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Low-Income Adults aged 19 through 64	Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act	Up to and including 133% FPL

	42 CFR 435.119	
Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E	Sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Social Security Act 42 CFR 435.145	An adoption assistance agreement is in effect under title IV-E of the Act; or foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E
Former Foster Care Children to age 26	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act 42 CFR 435.150	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	Section 1902(a)(10)(A)(i)(II) of the Social Security Act 42 CFR 435.120	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements; uses SSI payment standard
	Sections 1902(a)(10)(A)(i)(II) and 1905(q) of the Social Security Act 42 CFR 435.120	Qualified severely impaired blind and disabled individuals under age 65
	Sections 1634, 1634(a), 1634(b), 1634(c), 1634(d), and 1634(e) of the Social Security Act 42 CFR 435.121-122, 130-135, 138	Other ABD groups as described in the State Plan
Transitional Medical Assistance	Section 1925 of the Social Security Act 42 CFR 435.112	Coverage for one 12-month period due to increased earnings that would otherwise make the individual ineligible under Section 1931

1931 Extension	Section 1931(c)(1)-(2) of the Social Security Act 42 CFR 435.115	Coverage for four months due to receipt of child or spousal support, that would otherwise make the individual ineligible under Section 1931
Qualified Medicare Beneficiaries*	Sections 1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan
Specified Low-Income Medicare Beneficiaries*	Sections 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan

**Dual eligibles are included as those with full Medicaid benefits are served under QI health plans, and QI health plans pay Part B co-payments and coordinate Medicare services.*

Optional State Plan Groups

Optional State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	Sections 1902(a)(10)(ii) and 1905(a) of the Social Security Act 42 CFR 435.210	ABD individuals who do not receive cash assistance but meet income and resource requirements
	42 CFR 435.211	Individuals eligible for assistance but for being in a medical institution
	Section 1902(a)(10)(ii)(VII) of the Social Security Act	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care

	Section 1902(a)(10)(ii)(XI) of the Social Security Act 42 CFR 435.121, 435.230	ABD individuals in domiciliary facilities or other group living arrangements
	Sections 1902(a)(10)(ii)(X) and 1902(m) of the Social Security Act	Aged or disabled individuals with income up to and including 100% FPL
Optional Targeted Low-Income Children	Section 1902(a)(10)(A)(ii)(XIV) Title XXI of the Social Security Act 42 C.F.R. § 435.229	Up to and including 308% FPL, including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	Sections 1902(a)(10)(A) and 1920 of the Social Security Act	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.301(b)(1), 435.308	Up to and including 300% FPL, if spenddown to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Foster Children	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Children with non-IV-E adoption assistance
Foster Children age 19 and 20	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Receiving foster care maintenance payments or under an adoption assistance agreement under the state plan

Expansion Populations

Expansion Population

Eligibility Group Name	Qualifying Criteria
Parents or Caretaker Relatives with a Dependent Child age 18	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that they have reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 CFR 435.217 like Group Receiving HCBS	Income up to and including 100% FPL
Medically Needy ABD Individuals whose Spenddown Exceeds the Plans' Capitation Payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in a state plan or waiver while receiving assistance payments

Care Delivery System

Most beneficiaries are enrolled in mandated managed care and receive benefits through capitated managed care plans. All beneficiaries are eligible for state plan benefits (or, in the case of the Affordable Care Act childless adult group, approved benefits under the alternative benefit plan) and additional benefits (including HCBS and specialized behavioral health services) based on medical necessity and clinical criteria provided through an integrated managed care delivery system. For certain individuals, specialized and non-specialized behavioral health services are provided through Community Care Services (CCS), a separate behavioral health organization (BHO).

The State also uses a fee-for-service (FFS) delivery system for long-term care services for individuals with developmental or intellectual disabilities (via Section 1915(c) Waiver), Intermediate Care Facilities for the Intellectually Disabled (ICF-ID), services for applicants eligible for retroactive coverage only, services for certain medically needy non-aged, blind, and

disabled (ABD) individuals, medical services under the State of Hawai'i Organ and Tissue Transplant (SHOTT) program, targeted case management services, school-based services, early intervention services, and dental services.

Under the renewal, the State will continue the same cost-sharing policies. The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan.

Hypotheses and Evaluation Parameters

Table 2 presents a set of hypotheses intended to guide the evaluation of the demonstration renewal. These hypotheses are formulated to provide a framework for the evaluation, and specific evaluation measures and methodologies will be developed iteratively upon implementation of the intended programs. More specific evaluation measures and methodologies will therefore be submitted upon approval of the application via the revised evaluation design.

Table 2. Summary of Renewal Hypotheses and Evaluation Approaches.

Hypotheses	Evaluation Approach	Data Sources
CIS+		
CIS+ beneficiaries will receive different combinations of CIS+ services that match their needs, and tailoring services to fit needs will result in increased housing stability, improved wellbeing, and decreased cost of care.	Quantitative evaluation of the impact of CIS+ on health outcomes and costs; examination of differences in outcomes and cost among CIS+ sub-populations.	Encounter data, specific outcome metrics of interest (e.g., use of specific types of CIS+ services, inpatient utilization, etc.); cost measures where feasible may consider broader system-level costs; and as feasible, beneficiary self-reported data.
Continuous Eligibility		
Continuous eligibility will reduce churn and gaps in coverage for children enrolled in Medicaid, including for racial and ethnic minority populations that experience disproportionately high rates of churn.	Examine enrollment data by age, race, and ethnicity to determine trends in churn over time.	Measure is likely to be a calculated rate, broken out by multiple variables (e.g., age groups, particularly those that align with eligibility policy). Adjustments may be required to account for continuous enrollment during the PHE and PHE unwinding.

Continuous eligibility will reduce the quantity of redeterminations, resulting in lower administrative burden for eligibility workers and associated costs.	Examine case load of eligibility workers and associated personnel costs over time.	Measure is likely to be hours spent on redeterminations by eligibility workers and associated personnel costs, parsed by eligibility groupings to evaluate differences across Medicaid sub-populations.
Continuous eligibility will result in a slower rate of expenditure growth for children enrolled in Medicaid.	Examine differences in rates of growth in managed care capitation payments across actuarial groups.	Per Member Per Month (PMPM) costs during the waiver demonstration period; comparative populations or periods may be utilized to evaluate the impact of continuous eligibility on children.
Contingency Management		
Increasing the availability of Contingency Management will increase the number of Medicaid beneficiaries engaged in treatment for substance use disorders.	Mixed-methods approach that seeks to evaluate the implementation of guidance for Contingency Management services; network capacity for the provision of contingency management services; screening and identification of Medicaid beneficiaries with a qualifying SUD; and uptake of Contingency Management services among qualifying Medicaid beneficiaries.	Review of guidance, workflows and other documents to examine various aspects of implementation; examination of process metrics to assess progress of implementation; and encounter data to assess screening, identification, and uptake of services.
Participation in Contingency Management among Medicaid beneficiaries with substance use disorders will increase adherence to and retention in SUD treatment.	Evaluate utilization of Contingency Management and other concomitantly delivered SUD treatment services among qualifying Medicaid beneficiaries. Evaluate continued engagement in and adherence to treatment. Examine related and proximal health outcomes (e.g., evidence of ongoing sobriety,	Encounter data, specific outcome metrics of interest (e.g., ED visits for substance use), and QI health plan reports to capture utilization metrics and other data.

	Emergency Department (ED) visits/ admissions for relapse).	
Pre-Release Medicaid Services for Justice-Involved Individuals		
Implementation of pre-release services will result in increased collaboration between stakeholders, identification of unaddressed medical and health-related social needs prior to release, gradual expansion of access to pre-release services for justice-involved individuals, and improved insights into healthcare delivery for this population.	Use a mixed-methods process evaluation approach to examine the implementation of pre-release services, including the identification of eligible individuals, unaddressed medical and health-related social needs, and provision of Medicaid-covered services in the pre-release setting.	Qualitative interviews of stakeholders (e.g., QI health plans, MQD, and the State's Public Safety Division); review of guidance, workflows, and other documents to examine various aspects of implementation; and examination of health plan reports to assess progress of implementation.
Access to pre-release services will result in continuity of targeted health services upon release to the community, resulting in positive impacts on health outcomes.	Examine the post-release utilization of specific targeted health services including but not limited to CIS+ housing supports, those that address other identified health related social needs, and medication refills among individuals receiving pre-release services. Examine related and short term physical and behavioral health outcomes (e.g., stable housing, medication adherence).	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio), and QI health plan reports to capture utilization metrics and other data.
Nutrition Supports		
Implementation of nutrition supports will result in increased collaboration between stakeholders, gradual expansion of access to nutrition services for qualifying individuals, and improved infrastructure for the provision of nutrition support services.	Use a mixed-methods process evaluation approach to examine the implementation of nutrition support programs including the identification of individuals with food insecurity, referral mechanisms to existing non-Medicaid nutrition programs, and provision of Medicaid-covered nutrition	Qualitative interviews of stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan

	supports to qualifying individuals.	reports to assess progress of implementation.
Nutrition support services will result in reductions in food insecurity and improved disease management for participating individuals.	Assess the impact of each nutrition supports program on targeted outcomes. Examine related and proximal health outcomes (e.g., diabetes control).	Encounter data and QI health plan reports to capture utilization metrics and other qualitative data. Additional data may be collected at target delivery locations as feasible.
Native Hawaiian Traditional Healing Practices		
Integration of Native Hawaiian Traditional Healing Practices within the Medicaid delivery system will result in increased collaboration between stakeholders, gradual expansion of access to these services, and improved infrastructure for the provision of Native Hawaiian Traditional Healing Practices.	Use a mixed-methods process evaluation approach to examine the implementation of Native Hawaiian Traditional Healing Practices, including differences by setting if applicable (e.g., integrated vs. non-integrated settings); evaluate the uptake of Medicaid-covered Native Hawaiian Traditional Healing Practices.	Qualitative interviews of stakeholders (e.g., QI health plans, providers and overseeing bodies of Native Hawaiian Traditional Healing Practices, and MQD); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation. As feasible, qualitative interviews of beneficiaries receiving services, with the Consumer Assessment of Healthcare Providers & Systems (CAHPS) questions included to provide comparative analytics.
Native Hawaiian Traditional Healing Practices will increase engagement in Hawaii's health care system among Medicaid-enrolled individuals receiving Native Hawaiian Traditional Healing Practices.	Evaluate utilization of Native Hawaiian Traditional Healing Practices and other health care services (e.g., outpatient primary care and specialist visits, prescription medication use and medication refills, receipt of annual wellness visits, etc.) indicative of increased engagement.	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio, receipt of preventive services), and QI health plan reports to capture utilization metrics and other data.

	Examine related and proximal health outcomes (e.g., receipt of preventive health services).	
VBP		
Value Based Purchasing (VBP) expectations and requirements implemented by MQD will result in expansion of Alternative Payment Models (APMs) implemented by QI health plans.	Qualitative and quantitative methodologies to evaluate implementation and impacts of select APMs on health outcomes and cost of care.	Qualitative data to investigate APM implementation; encounter data, QI health plan reports on beneficiary and provider attribution, financial outcomes, and survey data on APMs to evaluate quantitative impacts.
Care Coordination		
Increased engagement in Health Coordination Services (HCS) will result in improved chronic disease management and health outcomes for individuals with complex health care needs.	Examine the implementation of HCS for populations with complex health care needs, including but not limited to those in CIS+, long-term services and supports (LTSS), and special health care needs (SHCN)/expanded health care needs (EHCN). Evaluate differences in implementation for specific sub-populations.	Encounter data, specific outcome metrics of interest (e.g., ED visits and inpatient hospitalizations), CMS core set/Healthcare Effectiveness Data and Information Set (HEDIS) metrics, and QI health plan reports to capture utilization metrics and other data. Additional qualitative data collection from QI health plans and/or providers may be conducted.

Waiver and Expenditure Authorities

The State believes the following waiver and expenditure authorities, as outlined in Tables 3-4, respectively, will be necessary to authorize the demonstration. CMS will review the requested waiver and expenditure authorities and approve as necessary to enable the State to conduct the approved 1115 demonstration renewal.

Table 3. Requested Waiver Authorities.

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Waiver Authority for All Section 1115	**Amount, Duration, and Scope** To enable the state to offer demonstration benefits that may not	Section 1902(a)(10)(B) of the Social Security	Yes

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Demonstration Benefits	be available to all categorically eligible or other individuals.	Act and 42 CFR 440.230-250	
Waiver Authority for QI Mandatory Managed Care	**Medically Needy** To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.	Section 1902(a)(10)(C); Section 1902(a)(17) of the Social Security Act and 42 CFR 435.831	Yes
	Freedom of Choice To enable Hawai‘i to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.	Section 1902(a)(23)(A) of the Social Security Act and 42 CFR 431.51	Yes
	Out of State Former Foster Youth To enable the State to receive federal financial participation and provide coverage for any individual who has aged out of foster care in another state prior to or after January 1, 2023 as eligible for Medicaid, subject to other applicable Medicaid eligibility criteria.	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act and 42 C.F.R. 435.150	No
	Cost Sharing To enable the state to charge cost sharing up to 5 percent of annual family income. To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QI health plan capitation rate, in the	Section 1902(a)(14) of the Social Security Act insofar as it incorporates 1916 and 1916A and 42 CFR 4472.52	Yes

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
	amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.		
Waiver Authority for HCBS	**HCBS Waiver** To enable the State to waive certain requirements under home and community based service programs, including provision of services through QI health plans for individuals assessed to be at risk of deteriorating to the institutional level of care.	Section 1915(c) of the Social Security Act and 42 CFR 441.301	Yes
Waiver Authority for Continuous Eligibility	**Periodic Renewal of Medicaid Eligibility** To allow federal financial participation for the continuous eligibility of children without regard to whether a child's income exceeds eligibility limits; and to enable the State to waive the requirements for individuals to report and for the State act on changes with respect to income eligibility.	Section 1916A(4) of the Social Security Act and 42 C.F.R. 435.916	No
Waiver Authority for Pre-Release Medicaid Services for Justice-Involved Populations	**State Wideness/Uniformity** To permit the state to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Nutrition Supports	**State Wideness/Uniformity** To permit the state to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Native Hawaiian Traditional Healing Practices	**State Wideness/Uniformity** To permit the state to provide Native Hawaiian traditional healing practices to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Waiver Authority for Contingency Management	**State Wideness/Uniformity** To permit the state to provide contingency management interventions to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No

Table 4. Requested Expenditure Authorities.

Expenditure Authority	Use for Expenditure Authority	Currently Approved
Expenditures for QI Mandatory Managed Care	**Managed Care Payments** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m): Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island. Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.	Yes
	Quality Review of Eligibility Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.	Yes
	Demonstration Expansion Eligibility Expenditures to provide coverage to the following demonstration expansion populations: <u>Demonstration Population 1</u>: Parents and caretaker relatives who are living with an 18-	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age. Demonstration Population 2: Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules. Demonstration Population 3: Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income. Demonstration Population 4: Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan. Demonstration Population 5: Individuals who are younger than 26, aged out of the adoption	

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non Title IV-E assistance), or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.	
Expenditures for HCBS	Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows: a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement; b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, i.e., the "at risk" population. The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees. The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.	Yes
Expenditures for CIS+	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for CIS+ services to qualifying individuals.	Yes
Expenditures for Continuous Eligibility	Expenditure authority as necessary to permit the State to implement continuous eligibility	No

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	and receive Medicaid matching funds for associated expenditures.	
Expenditures for CM	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for contingency management through small incentives to qualifying individuals.	No
Expenditures for Pre-Release Medicaid Services	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for costs not otherwise matchable for certain services, as described in this application, rendered to individuals who are incarcerated up to 90 days prior to their release.	No
Expenditures for Administrative Costs Related to Pre-Release Medicaid Services	Expenditure authority as necessary to permit the State to receive Medicaid matching funds for capped pre-release administrative expenditures for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure, and other interventions.	No
Expenditures for Nutrition Supports	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for nutrition supports to qualifying individuals.	No
Expenditures for Native Hawaiian Traditional Healing Practices	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for Native Hawaiian Traditional Healing Practices provided by eligible Native Hawaiian Traditional Healers to eligible individuals.	No
Expenditures for HRSN Infrastructure Funding	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for allowable infrastructure building expenditures related to HRSN services.	No
Expenditures for DSHP	Expenditure authority as necessary to permit the State to claim Medicaid matching funds for designated programs which are otherwise state-funded and not otherwise eligible for Medicaid payment.	No

Impact to Enrollment and Budget Neutrality

Enrollment

The Medicaid pause in redeterminations during the COVID-19 public health emergency (PHE) led to an historic increase in Medicaid enrollment. Between March 2020 and April 2023, enrollment grew more than 40%, from 327,119 to its peak of 468,120 in April 2023. Hawai'i began Medicaid redeterminations, also known as unwinding, in May of 2023.

Table 5. Enrollment Growth January 1, 2019 – September 18, 2023.

	2019	2020	2021	2022	2023**
Average Enrollment*	330,758	358,067	417,435	449,541	460,180
Percent Growth Year over Year	-	8%	17%	8%	2%

**Point in time measured weekly.*

***Data available through September 18, 2023*

The State is not proposing any changes that would negatively impact enrollment between Demonstration Year (DY) 31 through DY35. Further, several proposed authorities within this Section 1115 Demonstration, including continuous eligibility and the addition of pre-release services for justice-involved individuals, are expected to increase enrollment.

Table 6. Preliminary Estimates of Enrollment Impacts.

	DY31	DY32	DY33	DY34	DY35
Total Projected Medicaid Enrollment	396,427	408,441	418,405	428,814	439,932
QI Mandatory Managed Care	392,079	401,069	410,275	419,703	429,359
Continuous Eligibility	3,024	6,049	6,807	7,788	9,250
Pre-Release Services	1,323	1,323	1,323	1,323	1,323

Budget Neutrality

For the duration of the existing Section 1115 Demonstration period, the State continued to maintain strong positive variance and met budget neutrality requirements. The tables in the Section 1115 Demonstration amendment and renewal application provide a summary of Hawaii's projected with-waiver, without-waiver, and hypothetical expenditures for its Section 1115 Demonstration renewal, from DY31-DY35. These tables contain considerable detail regarding cost projections associated with each of the various proposed authorities.

Public Engagement

To produce the draft renewal application, Hawai'i developed and refined elements of its Section 1115 Demonstration renewal through a robust stakeholder and public engagement

process. Key to Hawaii's stakeholder engagement process has been its high-touch, accessible, and responsive engagement with local communities and organizations. In total, Hawai'i engaged dozens of stakeholder organizations and conducted over 30 stakeholder meetings to ideate, iterate, and vet details of the new initiatives proposed in this renewal application. For example, through stakeholder workgroups, Hawai'i cooperatively developed and obtained consensus of the details for nutrition supports, Native Hawaiian traditional healing practices, and CIS+ proposals. In addition to this preliminary stakeholder engagement work, Hawai'i will meaningfully engage in a public comment period to solicit and incorporate additional stakeholder perspectives, consistent with federal requirements.

Tribal Consultation

Historically, Hawaii's tribal consultation process as required by 42 CFR 431.408(b) was conducted with Ke Ola Mamo, the State's Urban Indian Organization partner. However, as of April 1, 2023 and at the time of this public notice, Ke Ola Mamo's contract with the Indian Health Services expired and MQD has no organization with which to complete the tribal consultation. As such, MQD has confirmed with CMS that there are no tribal consultation requirements to fulfill for this Section 1115 Demonstration renewal.

Public Notice

On October 16, 2023, the State will use an electronic mailing list to notify potentially interested parties of the opportunity to review the public notice and provide comments. On October 16, 2023, the State will issue a full public notice document with a comprehensive description of the proposed QUEST waiver renewal. Consistent with 42 C.F.R. 431.408, the notice will include the location and internet address where copies of the renewal application were available for review and comment; the dates for the public comment period; postal and e-mail addresses where written comments could be sent; and the locations, dates and times of the two (2) public hearing convened by the State to seek public input about the extension application. This public notice document will be available in a prominent location at https://medquest.hawaii.gov/ for the duration of the comment period.

Public Hearings

In concert with 42 C.F.R. 431.408(a)(3), the State will hold two public hearings to solicit public input and comment about the demonstration renewal application. Interested parties are invited to join the public forum and to state their views regarding progress on the Section 1115 Demonstration. Attendees may participate in the meetings in-person or via teleconference.

Registration is required to participate. If you plan to attend in person, please RSVP by calling 808-692-8058 or emailing PPDO@dhs.hawaii.gov. If you plan to attend via teleconference, participants must register for the meeting using the links listed below— participants will receive a confirmation email containing Zoom login information needed to join the meeting virtually.

- **Wednesday, October 18, 2023 at 6:00PM HST**

- *(In-Person)* Kakuhihewa Building, Conference Rooms 111 A&B, 601 Kamokila Boulevard, Kapolei HI 96707
- *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZcqd-Gspz0vGNOASTxnI_u1k9bo8QOXTkX-
- Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Monday, October 16, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.

- **Tuesday, October 24, 2023 at 6:00PM HST**
  - *(In-Person)* Queen Lili'uokalani Building, 2nd Floor Conference Room, 1390 Miller Street, Honolulu, HI 96813
  - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZwtd--opj8jGdHX86gdWXGW_WwoMgqbIIha
  - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Friday, October 20, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.

Public Comment

The State invites the public to comment on the draft Section 1115 Demonstration renewal application, available online at https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

A printed copy of the proposed changes and special accommodations (e.g., interpreter, large print or taped materials, etc.) can be arranged if requested by contacting the Policy and Program Development Office at (808) 692-8058 or via email at PPDO@dhs.hawaii.gov no later than seven (7) working days before the comment period ends.

Written comments may be submitted by email to PPDO@dhs.hawaii.gov using "Section 1115 Demonstration Feedback" in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR